

**NC DIVISION MH/DD/SAS
FY 2009/2010 CAP-MR/DD SERVICES AUDIT
PERSON CENTERED PLAN**

PROVIDER NAME:		AUDIT DATE:	
PROVIDER #:		NAME:	
CONTROL #:		DOB/AGE:	
MEDICAID #:		WAIVER:	
RECORD #:		PC PLAN DATE:	
TARGETED CASE MANAGEMENT PROVIDER:			
RATING CODES:	O = No 2 = partially met 4 = Yes 9 = NA Questions 1, 2, 3 and 6 are Yes/No; Questions 4 and 5 are Likert (See Instructions)		RATING
1. Was the CNR process completed by the end of the individual's birth month?			
2. Was the PCP signed by the Individual/LRP indicating they were given a choice of providers?			
3. Was the PCP signed by the individual/LRP indicating they were given a choice between an ICF-MR service and Waiver services?			
4. Does the PCP reflect the assessed needs and preferences of the individual?			
5. Does the PCP include strategies to address health and safety risks identified in the Risk Identification Tool?			
6. Was there an update completed within the current plan year?			
COMMENTS:			
AUDITOR:		LME:	